Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

If you would like to prescribe a Preferred Drug, Please do so in the space provided and **FAX form back to the dispensing pharmacy**. Otherwise, continue with the Prior Authorization process by completing the rest of this form & FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka)	**Rx** _____ _____ Physician signature Date

Unless otherwise indicated, the chemical name includes branded products and all dosage forms.

DRUGS for ALLERGIES - Non-Sedating Antihistamines

NOTE: Over-the-counter (OTC) forms of the brand Zyrtec® are not covered under KMAP due to labeler non-participation in the Federal Drug Rebate program. Legend Zyrtec® products remain preferred. Cetirizine OTC is preferred for labelers participating in the Federal Drug Rebate program.

Preferred Drug Covered		**Non-preferred Prior Authorization Required**	
Cetirizine	Zyrtec® Zyrtec Syrup®	Desloratadine	Clarinex®
Cetirizine / Pseudoephedrine	Zyrtec-D® **KBH only**	Desloratadine/ Pseudoephedrine	Clarinex-D 12-hour® Clarinex-D 24-hour® **KBH only**
Loratadine	Claritin® Claritin 24-hr Allergy® Claritin Hives Relief® Claritin RediTabs® Claritin® Syrup	Fexofenadine	Allegra® Allegra ODT®
Loratadine/ Pseudoephedrine	Claritin-D12® **KBH only** Claritin-D24® **KBH only**	Fexofenadine / Pseudoephedrine	Allegra-D® **KBH only** Allegra-D24® **KBH only**
		Non-preferred	
		Levocetirizine	Xyzal®

**** Indicates REQUIRED information**

****CONSUMER NAME:** _____ ******Medicaid Number:_____

****PHARMACY** Name**:**_____******Phone #:_____**Fax #:_____

****** Medicaid #:_____**NPI #:_____******NDC:_____

****** ***Indicate:*** Non-Preferred Drug prescribed: _____ Other:_____

****PRESCRIBER** Name**:**_____******Phone #:_____**Fax #:_____

******Medicaid #:_____ NPI #:_____

****** ***Indicate:*** Preferred Drug tried: _____ Length of trial: _____

****** ***Check:*** the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:

☐ Medical intolerance to Preferred Drug. **Provide clinical symptoms**:_____

_____

☐ Inadequate response to Preferred Drug.

☐ Absence of appropriate formulation or indication of the drug. Please specify:_____

_____

******Prescribing Physician's signature: _____Date: _____

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593.

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